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ABSTRACT

Health planning is a complex procedure in the American federal system of multi-authorities and multi-levels of responsibility. Because of its public nature, responsibility for the area of health planning is delegated to the health professional for its substantive dimension, but to the politician-bureaucrat and public-decision-maker for its policy dimension. This analysis of health planning discusses: (1) recent historical context of health planning--hospital construction, the Comprehensive Health Planning Act of 1966; (2) issues addressed by the National Health Planning and Resources Development Act of 1974; (3) components in health care systems--federal, state, local; (4) "comprehensive planning"--all details and resources delineated before implementation; (5) "incremental planning"--long term planning calling for interim reconsideration in the light of initial experiences; (6) methods for different steps in the health planning process: (7) elements in health planning services--needs assessment and types of services; (8) Bureau of Health Planning guidelines; (9) resource allocations in health system agencies; (10) strategic health planning and marketing orientation; and (11) problems with current health planning programs. (JD)

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HEALTH PLANNING

by

Dr. Moses Stambler

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INTRODUCTION

The health field is a growing and expanding field for planning development. Advances in planning are needed because of the technological advances in medicine, the value system that advances access to this medical technology, the cost factor of making medical care available, and the increased demand for the available medical supply. The presence of changing and expanding services and the limited supply and increased demand for these changing services requires some orderly type of policy and reasonable planning to achieve policy objectives.

The cost of medical care in the United States is an important input which leads to the shaping of federal planning involvement. From the time of governmental involvement in the health care field, it has, in a sense, become a partner in the health operation, and costs are not just for the individual to bear in the libertarian sense, but a social issue as well. The nation's medical care bill grew tenfold between 1960 ($27 billion) and 1981 ($275 billion). The average cost of hospital stay increased in a ten year period from $670 in 1971, to $2,119 in 1981. (Stevens, 1) Almost one dollar in every 10 generated by the American economy is spent on medical care, compared to a lower percentage of 1 in 20, only 20 years ago. The Federal medical budget for medicare and medicaid is 9% of the Federal budget. In addition to the dollar costs, in 1981 there were in 1981 approximately 7 million people employed in the medical industry (Stevens, 1). Health care is clearly an important area for planning.

Planning in the health field requires that two areas be considered and utilized, competence in health planning skills, and political competence. Because of its public nature, the area of health planning is generally delegated to the health professional for its substantive dimension, but to the politician bureaucrat and public-decision-maker for its policy dimension (Stambler, passim).

A. RECENT HISTORICAL CONTEXT OF HEALTH PLANNING

There have been seven trends in health planning dating back to the mid-1940's (Spiegel, 9-10). These are: Greater involvement of citizens and consumers; A trend toward regional planning; A trend toward more comprehensive planning toward regional services and total health care; A shift from private expenditures to greater federal participation in medical care costs; The development of more adequate planning staffs at health planning agencies; More effort at coordination and integration of health services; and Movement away from the dominance of the private voluntary sector to a partnership with all levels of government (Spiegel, 9-10).

What has been the recent federal role in health planning?

Hospital Construction and Survey Act of 1946 - The Hill Burton Act

The Hill Burton program provided funds for hospital construction in underserved areas (primarily rural), and set up a planning process for the allocation of funds. States were awarded funds for organizing planning councils to survey the need for hospital beds, and then awarded funds for construction of hospital beds according to the plan. In 1965, the Hill Burton Act was amended to include projected population levels, rates of hospital use, and target of occupancy rates.

Between 1946 and 1974, Hill Burton resulted in the addition of 496,000 inpatient hospital beds, and 3,450 outpatient units for a total cost of $4.4 billion, 15% of total hospital investment. (Congressional Budget Office, 54)

The Comprehensive Health Planning (CHP) Act of 1966. This act funded both state and local planning councils. Formula grants were awarded to the states, and local councils were given grants after approval by state agencies. By 1974, there were 56 state and 218 local CHP Agencies. Federal funding for these agencies averaged about $22 million over the eight years of agency existence, with most of the required local matching funding coming from hospitals. Both state and local planning councils were

required to include both providers and consumers (as a majority group). Two serious limitations on the CHPs was low level funding and lack of authority to change the health care system (Congressional Budget Office, 55-56).

The National Health Planning and Resources Development Act of 1974 - PL-93-641

This act and its 1979 amendments, consolidated and expanded the federal role in health planning. As in the CHP, state and local agencies were designated to carry out planning tasks. Authority was given to these planning agencies by the requirement that all states pass Certificate of Need legislation (CON) in which decisions were based on health plans and planning agencies. Federal standards and process guidelines gave more directions to planning agencies in developing their health plans. Funding was more substantial than under the CHP legislation. (Congressional Budget Office, 56). This act became law on Jan. 4, 1975, and included the following components:

Title XV - This concerns the development and functions of the area-wide and state planning agencies. It sets forth national health priorities requiring area wide and state health plans. It establishes the basic unit. Health Systems Agency (HSA) for geographic population of 500,000 to 3 million. It provides for highly specialized services nonprofit or public regional planning body, or a single unit of local government. In

1979 most were non profit (177), 25 were govt. sponsored and 57 were State Health Planning and Development Agencies (SHPDA)

Title XVI - This focuses on health facilities planning (substitute for Hill Burton) and mandates a relationship between the development of state health systems or plans, and the facilities these plans call for. Local planning agencies are empowered to assess area health needs, set priorities, and attempt to direct resources to most needed areas. These agencies also conduct Certificate of Need (CON) reviews which is their major role for controlling hospital costs. (Congressional Budget Office, ix)

Between 1976-1981 federal (?) funding for health planning averaged $130 million annually. In 1982, there was a funding reduction to $58 million. Funding is scheduled to terminate at the end of 1982, with the Reagan administration committed to termination of the complete program.

B. ISSUES ADDRESSED BY THE NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974

Problems associated with the allocation of health resources under the 1974 legislation include: excess capacity, unnecessarily duplicated services, high hospital costs, uneven distribution of health services.

What are the key reasons for the above problems of resources allocations? Factors that encourage overinvestment, e.g., extensive

third party reimbursement, availability of tax exempt financing, and competition among hospitals for physicians. Inadequate consumer involvement in decisions pertaining to available health care are also at fault. (Congressional Budget Office, ix).

The different operational levels and their tasks in the health care system are noted on Table I.

TABLE I - COMPONENTS IN HEALTH CARE SYSTEM

FEDERAL

Role:
Requires
Health Systems Agency (HSA) to address wide-ranging national priorities, and to consider health resources, service delivery, health education, and other aspects of the health system.

Council on Health Planning and Development (20 members)
Bureau of Health Planning

STATE HEALTH COORDINATING COUNCIL (SHCC) Appointed by governors as required by 1974 act.

Review HSA plans and has final approval over state health plans of SHPDA

STATE

- State Health Planning and Development Agencies (SHPDA) (In most states, state health dept.)
- State government agencies chosen by governors to prepare and implement state health plans based on HSA
- Make final Certificate of Need (CON) review decisions; Consider recommendations of HAS's

LOCAL

- Health Systems Agency (HSA) independent organizations (up to 60% consumers on Board)

Roles
1. Gather Data
2. Analyze health statuses, health needs, available resources and use of health services
3. Design a comprehensive health plan to outline a strategy to improve the quality and distribution of health care (5 yr. plan must be updated every 3 years)
4. Make recommendations to State Planning agencies for CON applications.
5. Advocate services from providers.
6. Agencies vary greatly from education to stimulating competition.

B. PLANNING MODES

Three factors are prerequisites for social planning: (1) some underlying notion of how we would like things to be, (2) some knowledge, or perhaps only assumptions, about how things are, and (3) a proposal for how to get from the way things are to how we would like them to be - how to get from here to there. Despite its cohotic appearance, our health system is the result of planning. Most of the planning, however, has not been visible, because the important decisions and their enforcement take place in professional and trade councils, an implicit mode of planning, rather than non-planning. By contrast, in explicit planning the intention to plan is clearly brought out for public consideration and approval or rejection.

There are two principal styles of planning which are the polar types in health planning. These are comprehensive blueprinting, and incremental (the process mode), of planning. The comprehensive mode of planning spells out all details and delineates all resources before implementation. A final outcome is specified for a specified future time, possibly a year or more. In the incremental or process mode of planning (Lindbloom) a longer term plan is drawn up but part of the plan calls for interim reconsideration in the light of initial experience. Also, incrementalism identifies local issues and develops solutions to them on an ad hoc and issue-by-issue basis.

The comprehensive view would have more distinct values and objectives, rather than empirical inputs, and would require a more comprehensive means-ends analysis. Comprehensive planning would also rely more on theory, and alternatives of proven merit as compared with a reduced role of theory and consensus of parties involved. The incremental model would be more in line with feasibility and utilize a "force field" analysis to decide how objectives are to be achieved.

A rational planning mode in health is limited by the clarification of public demands, official policy guidelines, legal constraints and available resources. There are also the value questions involved in determining what are the merits of one type of health expenditure over that of another. A rational planning mode is also limited by the need to clarify issues and techniques through application, an instrumental view of truth.

The two polar models of planning, are identified with two types of agencies functioning in health planning; the central planning agency(of the type found in local and national government, and the agglomeration of different representational groups (of the type found in a health and welfare council of a community). In council types of agencies, different groups or agencies push for plans for particular value and interest to them. The process is one of political process and brokering and compromise is an important way of reaching decisions.

The HSA operates on two levels, both formulating a five year plan, and renegotiating the plan on an annual basis. It has a legal obligation to include representation from different constitutencies, and the need to obtain their approval.

A Comprehensive health service system would be one which is able to include all levels at a particular type of care: acute short term, ambulatory care, patient's home and emergency, inpatient long term, services ancillary to direct medical care, and the planning units that coordinate these into a comprehensive whole. (Shonick, 1598)

The comprehensive and incremental styles to planning may utilize different methods to achieve goals in the health planning process spelled out by PL 93-641 (to improve health of residence in the service area, to provide for acceptability, continuity and quality of the health services, to restrain increases in cost and to prevent unnecessary duplication of resources). These are:

1. Population Based-Planning identifies national health pattern and based upon social epidemiology, recommends plans services for high risk populations in its domain. This approach can be revisionist if the "at risk" population and services differ from the national norm.
2. Institution Based-Planning - Identifies health situation based on institutional perspective. This can be comprehensive if an

institution has a large base, or it can be "strategic planning" if an institution is market oriented.

3. Program planning. It is usually restricted to the population specifically targeted by the program. This planning is involved in programs such as maternal and child health, periodic screening and diagnosis or immunization. A collection of program plans is often part of a more comprehensive population based plan. (Shonick, 1598) It is an amalgam between institution and population based planning.

4. Resource Planning - Analyzes the availability of resources and plans to fill the gaps and reduce duplication and inappropriate distributions. It estimates the demand for various types of service in settings and then supplies that amount. In this type of planning, the interest groups with the loudest voices would probably have their option selected from the available alternatives (such as choosing from the many options for reducing automobile deaths). This method can be effectively used with the incrementalism made as essentially conservative and status quo oriented, and assumes that the system is meeting the needs of all people who really require service.

There are in addition other planning methods identified by Spiegel based on geography, socio-cultural factors and political constraints. These types are:

1. Problem solving planning - Identifies the problem and proposes a solution. Determining whether or not a situation should be defined as a problem is the critical matter in this case.
2. Coordination of efforts and activities planning.

   This would include hospital and facilities planning whereby various organizations coordinate their efforts.
3. Planning for the creation of a plan

   This type of planning would develop a blueprint for action and is commonly the practice of a commission or special task force.
4. Planning a design of standard operating procedures

   In this type of planning, the planner would develop sets of standards of practice or criteria for operation and evaluation. This is generally planning mandated by legislation and usually involves consensus of concerned parties (i.e. inpatient care guidelines were mandated by law and resulted in Professional Standards Review Organizations) (Spiegel, 10-13)

Methods For Different Steps in the Health Planning Process

Each of the steps in the health planning process can utilize methods particularly appropriate for that step.

Step 1 - Identifying the problem. Methods used on this step should result in needs assessment and final report analysis. It can include such methods as: key informants, community forum, social indicators, survey, serviced population, and the RUT (rates for those under treatment) approach.

Step 2 - Health resources. These should be inventories in terms of manpower, materials, money. Some type of inventory of resources grid should be established.

Step 3 - Generating and considering alternative courses of action. This step would include brainstorming, think tanks, etc.

Step 4 - Priority Setting. Some of the federal health priorities are spelled out in PL 96-431 (Spiegel, 179-238)

Step 5 - Promoting Implementation. This includes an understanding of the ecology on the National level of decision-making: the social organization, political structure, economic structure, religious organizations educational structure, medical organization, power structure, physical characteristic special problems, govt-state programs, demographic characteristics, social class structure, special interest groups, and

geographic characteristics (Spiegel, 240-241). The question and viability of citizenship participation would be raised on this step.

Step 6 - Evaluation - This step includes a multitude of methods for evaluating health planning to determine if the activity has been worthwhile and should be continued. Five sub-categories for the evaluation in health might be, Effort, Performance, Adequacy, Efficiency, and Process.

Braden identifies three levels on which planning takes place on the basis of centrifical or centripital forces. These are "Dispersal," "Focused" and, "Central" (Braden, 99). "Dispersal" or project planning emphasizes the individualistic role of the components. It is the most commonly used planning form in the health field, and results in both gaps and overlaps of service. An example of this planning approach is the multiple health services that can be found in most cities. The next step toward centralized planning is "Focused" or system planning. This approach is based on voluntary association of system linkages but there is little or no control over available resources because of the voluntary aspect. The last type of planning is "Central" or policy planning on the macro-level. This is not a voluntary association but is one bound by legislative enactment. Change is affected through allocation of resources through a central plan.

Hyman has developed a typology of planning models that are actually operational in the health planning field, based on typologies from generic planning areas (Hyman, 102-193). The major models of planning agencies in this typology are: Systems, Partnership, Alliance and Individual Action. This typology is based on the degree of control held by the health planning agency over resources to plan and implement particular models. The greatest amount of control is assumed by the "Systems" model, and one using it is best able to integrate socio-environmental medical delivery goals. At the other end of the spectrum is the "Individual Action" model which has a narrow based, homogeneous group with narrow interests in program implementation, but little concern for the aggregate of medical and health programs. This type of "Individual Action" is the basis for ad hoc planning and the model is characteristic of adaptive local agencies with a focus on incremental improvements in programs and systems delivery. The characteristics of these four models can be differentiated on the basis of Decision-Making, Main Direction of the Agency, Primary roles of the health planner, Center of Influence, Strategies for Goal Achievement, and Commitment toward Goals. (Refer to Appendix [ ] Table 4-1 Typology and Selected Characteristics of Models of Planning Agencies (Hyman, 102-193)

A health planner requires a high degree of technical competence in the field to negotiate the many modes and methods. There seems to be a disparity between concepts of health planning and actual practices of health planning, suggesting the need for developing more effective planning practices by the health profession (Spiegel, 3).

C. ELEMENTS IN HEALTH PLANNING SERVICES

The elements of planning differ depending on which type of health agency is the client. Health service institutions such as hospitals, or health maintenance organizations (HMO's) do planning which is called "Institution based" planning. Although consideration is given to general assessments of population, the major focus is on the requirements of the institution. They are more interested in market demand, and ability to pay, than human need and the public health function. Local health planning agencies on the other hand (HSA's) are involved in population based planning, they focus in a specific jurisdiction and attempt to specify the resources needed to meet the health service requirements of that particular population. They focus on identifying (assessing) the health needs of small areas, and are tied to the public health function. This comprehensive population based planning begins with health status evaluation and ends with required resources. The steps in this procedure are: determining population health status, identifying the health services required

to improve or maintain the health status, and the health services resources required to provide these services.

For comprehensive population based planning to determine the health status, census reports or surveys are used. To determine health service needs, planners study reports of outcome measures and studies which show the effect of therapeutic or preventive interventions on these outcome measures. Comprehensive population based planning requires knowledge about the relative value of different interventions, evaluated on a cost-effective basis. But the final decision must take into account the local preferences and biases. Comprehensive planning agencies usually consider plan components over time as part of their package intervention: preventive, therapeutic, rehabilitative and long-term maintenance and ancillary services associated with these health services. (Shonick, 1602). However, most comprehensive health planning agencies concentrate almost exclusively on medical care service planning.

Planning Guidelines of the Bureau of Health Planning

The planning guidelines of the Bureau of Health Planning are primarily population based and center on the health needs and status of the population rather than the needs and problems of the medical system. PL 93-641

indicates the following steps it expects the State Health Planning and Development authorities (SHPDA) and HSA (Health Systems Agency) to follow (Hyman, 115):

1. Study of the health status of the population and the medical system serving it
2. Identification of the gaps between the needs of the population and the services available to meet them
3. Setting of goals and objectives
   - use of health status indicators
   - use of health system indicators
   - ranking of goals and objectives
4. Recommendation of alternative actions to achieve goals/objectives
5. Identification of resources for service development
   - facilities
   - personnel
   - equipment
6. Evaluation of goal achievement through periodic assessments of services required by the appropriateness review function

These steps, follow the regular rational planning process method. However the act also calls for a two-tier process which requires development of two plans, by the HSA's. The HSP (Health Systems Plan) which focuses on diagnosis of priorities and long-range goals, and the AIP (Area Implementation Plan) which focuses on implementation the first year of the HSP and how many and to what extent long range goals are achievable during the first year of the plan.

The long range HSP is required to project on a dimension of at least a five years the desired goals in the area for levels of health status, desired performance of the health system, and the desired level of resources. Goals must be quantified and measurable Health status indicators include infant mortality rates, and the incidence of various medical disabilities.

Indicators generally have one or more of the following characteristics: availability, accessibility, continuity, quality, acceptability and cost. The HSP includes long range quantifiable objectives to be achieved within stipulated time limits. Strategies to achieve these objectives must be delineated, and resources required to carry out the action specified (Hyman, 116-117). The HSP planning process is required to link goals, objectives, actions and resources. (Hyman, 118)

The AIP is generally limited to one year and delineates objectives of the HSP that can feasibly be achieved during the one year period. AIP strategies are listed in very specific detail. (Hyman, 117)

Health System Agencies - The HSA - Where The Money Goes

Community Health Planning, is mostly the function of HSA's which differ dependent on the area they service. In 1980 the typical HSA served an area of approximately 1,000,000 people, was funded at approximately .40¢ per capita, involved approximately 200 citizen volunteers, and spent in money and staff time the equivalent of the following:

1. Agency organization and management - 20% of resources (includes HSP 5 yr plan and AIP 1 yr. plan)
2. Plan Development (the major functional activity) 21% of resources
3. Plan implementation and health systems development (15% of resources)
4. Plan implementation review activities including Certificate of Need (CON Review) and Proposed Use of Federal Funds (PUFF Review) (18%)
5. Data Management and Analysis of resources. Collecting and analyzing data already published (app. 10% of resources)

6. Coordination of meetings with health groups (5% of resources)
7. Public involvement and education including development of worshop seminars and activities to improve public awareness (11% of resources) (Cain, 161).

The above percentages are generally the amount spent irrespective of the size of the agency.

Strategic Planning

A major emerging element in health planning "Strategic Planning" fits in well with the Reagan administration concept of "Market Economy."

This significantly different form of health planning, has emerged as a result of bringing market-place considerations to hospital planning. This is a change in traditional concepts of hospitals, and their roles in the health environment, and what has emerged as result is a concept of business and market place strategic planning (Thieme, 35).

> From the end of World War II through the mid-1960s, rapid hospital growth was fostered by the availability of both government funds (e.g., Hill-Burton) and private philanthropy. The chief manifestation of hospital growth

> during this period was the expansion of physical facilities; accordingly, the focus of hospital planning tended to be facility planning and construction.
>
> In the late 1960s public support for continued growth began to moderate. Concern over unfettered hospital growth and the increased consumption of public monies led to numerous government initiatives to constrain growth. Most prominent of these were the Health Planning Act (PL 93-641) and resulting certificate-of-need laws, professional standards review organization legislation, and various federal and state expenditure caps and rate-setting schemes. These initiatives were accompanied by a dramatic decrease in philanthropic support for hospitals.
>
> The effects of these environmental changes on hospitals have been dramatic and, in some cases, traumatic. It has become necessary for trustees administrators and physicians to rethink their criteria for judging institutional success and measuring progress. Many institutions have been forced to make difficult choices about the number and types of services offered. One highly important result is that the nature of planning in hospitals has changed and continues to evolve. This planning evolution can be characterized as a change from facility planning or "master planning" to long-range strategic planning or "strategic planning."

Strategic planning a marketing orientation is a dramatically different approach to health planning and embodies four features: it shifts approach for needs and manufacturing to meet needs, to demands, and ability of public to pay for and secure delivery of health services. It is also removed from idealistic statements about mission. There are no real assumptions about mission that supercede marketing interests. If

mission is to be used, it comes after rather than before market analysis of external federal regulations, competitive assessment, consumer demands and delivery needs. Mission therefore becomes identified with economic and business reality rather than the needs of consumers. Institutional interest for economic survival becomes the end goal and service delivery is important to the extent that this end goal is facilitated. (Thieme, 35-43)

D. PROBLEMS WITH THE HEALTH PLANNING PROGRAM

Reports by the Congressional Budget Office

Problems of design and implementation are of two types. Those that can be ameliorated through changes in the current health planning programs; and those that would be difficult to solve through program changes." (Congressional Budget Office, 31)

> Problems Related to the Current Planning Program include 1. Unclear Goals. It is widely thought that confusion about the mission of the health planning program has limited its effectiveness, or at least has hampered evaluation of its effects. Planning objectives vary across federal, state, and local agencies, among agencies at the same level, and within a single agency...
>
> Statutory requirements and federal management have both contributed to this uncertainty. The planning act lists 17 wide-ranging priorities for the program, including cost control, improved access to services, quality of care, and efficiency in health-care delivery...

An important facet of this confusion is that cost containment has been a much more important goal for the federal government than for most state and local agencies. Many state CON laws are intended to improve the distribution of health services rather than limit investment and total costs.

2. Limited Authority. The limited authority of state and local planning agencies under the federal planning program is a serious obstacle to implementation of their health plans. HSAs and state planning agencies have no direct authority to enforce their health plans, but must rely on encouraging voluntary actions by health care providers, state and local health agencies, and other community organizations.

In addition, there are a number of problems that are related to the concept of health planning and would be difficult to solve by changing the structure or implementation of the current program. (These) include difficulties in developing and applying standards and with local planning, and costs of CON review.

There also are difficulties in developing and applying standards.

Unfortunately, much of the information necessary to define a population's need for health services is not available. First, detailed data on the health status of local populations often do not exist and would be very costly to collect. Second, little is known about the effects on people's health that changes in various health services would have. For example, the overall health benefits of establishing additional surgical facilities is unknown.

Other difficulties with local planning include

Two problems related to local planning could limit successful cost containment: the lack of local incentives for cost control, and the potential for providers to dominate the planning process. (Congressional Budget Office, p. 35)

In addition there are (Congressional Budget Office, X, XI:)

1. Unclear and conflicting goals between federal, state and local planning.
2. Except for the Certificate of needs (CON) review based on supplier proposals, planning agencies have little real authority.
3. Reluctance of hospitals to accept planning agency recommendations to merge, share services or otherwise cooperate.
4. Hospitals can invest in equipment not subject to CON review.
5. Local governing boards and other federal regulation might not be contributing to more effective services.

Political and evaluative problems with the current program include (Congressional Budget Office, XI):

1. Lack of adequate data on how health services translate into improved health.
2. Costs of overinvestment generally are shared by areas which overlap planning areas. Planning agencies don't want to come down hard on their own services if those services outside of their areas can't be controlled.
3. Cost of Certificate of Need (CON) review is very high.

Reports by the National Council on Health Planning and Development

In December 1980, the National Council on Health Planning and Development surveyed over 67 health planning agencies and planners regarding

issues of simplification of health planning, stablization of funds for planning, and other health planning issues. Responses to their inquiry on simplifying the planning process included views on the composition of governing bodies in health planning (National Council on Health Planning and Development, 141-42).

> ... Composition requirements are too complex: there are too many categories for too few slots, and trying to fill vacancies in light of this is too restrictive. (Responder's) recommendations include: Having simple consumer majority...; Eliminating consumer/provider seats; Limiting governing body size...; Stressing business and industry participation; Having equal number of providers, third party payors, consumers, governmental representatives...; Federal government standardizing selection, composition and size.

Responses to their inquiring on the CON included that the certificate of need be streamlined, some thought the Section 1122 program was duplicative of CON and should be repealed.

Comments to their inquiry on the Appropriateness Review included

> "... that the review process be eliminated and made part of the routine planning process; (or) to eliminate it entirely, ... (or that) it be optional." (National Council on Health..., 143)

Comments on Approval of Federal Funds included:

> ... that the function be eliminated (as only marginally useful) or that it be made optional; ... changing the thresholds for review. One frustration in the field is that if a project is turned down in an area, the funds will go to another area. (National Council on Health..., 143)

Comments on administration included:

> ... to reduce the administrative and procedural aspects of the program, and to focus on outcome. Many comments attributed this problem to federal administration..." (National Council on Health..., 143)

What are the actual policy options for changing the health planning program?

There are four broad options available to change the federal health planning programs. These are (Congressional Budget Office, 39)

1. End the federal requirement for health planning and eliminate funding for it (Administration proposal);
2. Continue the federal role, either by maintaining the current planning program with modifications to increase the focus on cost containment, or by providing grants to those states that chose to have planning programs;

3. Offer funding for health planning in the context of a broad program of incentives to the states to contain hospital costs and;
4. Limit hospital investment by eliminating tax-exempt bonds for private hospital construction.

The Federal government has evidently opted for option 1, as reflected in the following position statement by Edward Brandt, Assistant Secretary for Health, USDHHS, for the Reagan administration. He notes that the administration has opted for reduction of Federal involvement in health planning, and locating this function in the states or the local levels. (Brandt, 94-97)

> A major element in the President's proposed economic recovery program is the reduction in the growth of government... we are recommending that their authorities and resources be transferred to the states and to the private sector, where the final decisions on program scope and use of resources may be more appropriately made.

This transfer will be done in the form of proposed "block grants" - consolidations of 25 health services programs from the 69 categorical

grant-in-aid programs administered by the Public Health Service. The block grants are a part of the effort to reduce the level of federal expenditures and an effort to (Brandt, 94-97):

> "...restore a proper constitutional relationship between the federal, state, and local governments... We plan to phase out all federal support for professional standards review organizations by 1983,"
> ... and for state and local health planning. This is not to be interpreted as a dismissal of planning as a useful tool for health administration. Rather, it reflects the strong belief - to which I completely subscribe - that we must "return government to those closest to the people most affected." ... This administration is not convinced that a national health planning standard is either fair or effective. Hence, we are phasing out this federal program,
>
> Consistent with that notion is our decision to remove the federal government from some of the delivery of health care and medical service. In most cases, the federal programs have been actually carried out by public and private organizations at the state and local levels. In the case of the public health service hospitals, we believe the original need of two centuries ago has long since been fulfilled... Three areas where the federal role is appropriate and will be strengthened in this administration. Expanding our knowledge base through research, developing further the concept of prevention, and providing aid in emergencies.

It is questionable of the above position statement by the Reagan administration can be carried out in the health planning arena. The recent congressional elections of November 1982, resulted in an underculting in congressional support for the broad ideological basis for the Reagan program. In addition, socio-economic problems related to an economy in recession suggest an increased defensive posture for an administration under increasing fire.

CONCLUSION

Health planning is a complex procedure in the American federal system of multi-authorities and multi-levels of responsibility. There is no uniformity of planning modes, and diverse levels and elements in the planning of health services. The many problems associated with health planning in the United States reflect the limitations of an open system directed at a moving health systems target.

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